

WEST VIRGINIA INFORMATIONAL LETTER

No. 17
April, 1983

FORM AND RATE FILING ABSTRACTS
for
ACCIDENT AND SICKNESS INSURANCE FILINGS

This informational letter is intended to assist insurers in preparing filings by providing a standardized format in which basic information in support of filings may be presented. This informational letter does not alter statutory filing requirements for any form or rate.

This informational letter is issued pursuant to that authority granted to the Insurance Commissioner by Chapter 33, Article 2, Sections 3 and 10 of the Code of West Virginia of 1931, as amended, in order to implement the following articles of that Chapter: Article 6; Article 15; Article 16; Article 16A; Article 23; Article 24; Article 25; Article 25A; Article 28; and Article 29.

Effective June 1, 1983, each accident and sickness form filing submitted to the Insurance Commissioner for approval shall be accompanied by Form Filing Abstract Form ASA-F-83. Each rate filing shall comply with the Accident and Sickness Insurance Procedural Information Form ASPI-R-83, and shall be accompanied by Rate Filing Abstract Form ASA-R-83. If a combination of forms and rates are to be filed, they shall comply with Forms ASPI-R-83, ASA-R-83, and ASA-F-83; all materials and filing abstracts shall be filed together.

Rate Filing Abstract Form ASA-R-83 and the Accident and Sickness Insurance Procedural Information Form ASPI-R-83 are not required for filings made pursuant to Chapter 33, Article 14, Section 3, and Article 16, Section 2(e) of the Code of West Virginia of 1931, as amended, all relating to the filing of rate deviations for debtor (credit) group insurance contracts.

In the interest of uniformity, the abstract forms shall be reproduced only in exact copies of those issued pursuant to this informational letter; however, they may be reproduced on the front and reverse sides of paper, if so desired.

Filings not accompanied by the appropriate properly-completed abstract forms may be disapproved without further review and/or consideration.

Richard G. Shaw
Insurance Commissioner

INSURANCE COMMISSIONER
STATE OF WEST VIRGINIA

ACCIDENT AND SICKNESS INSURANCES
FORM FILING ABSTRACT

INSTRUCTIONS: All questions must be answered; if no answer is applicable, enter the reason for such determination. If this filing is a combination form and rate filing, the Rate Filing Abstract Form ASA-R-83 must also be completed.

1. Date Filed: _____ Proposed Effective Date: _____
2. Company Name: _____
3. Policy/Contract Type(s) Affected: _____
4. Reason(s) for Proposed Form Changes/Filing: _____
5. Section 16-29B-24(b) of the Code of West Virginia of 1931, as amended, requires that a copy of any rate and/or coverage filing must be submitted to the West Virginia Health Care Cost Review Authority, West Virginia Department of Health, on or before such filing is submitted to the Insurance Commissioner. Please enter the date on which a copy of this filing was submitted to said Authority: _____
6. Provide on Page 2 of this Form ASA-F-83 the requested information for each form being filed, revised or withdrawn. Attach additional sheets if necessary.

CERTIFICATION: I hereby certify that the information contained in this Form Filing Abstract is true and correct to the best of my knowledge and belief, and that a true and complete copy of this entire filing has been submitted to the West Virginia Health Care Cost Review Authority as stated herein.

(Signed) _____

(Title) _____

FORM NUMBER	REPLACES FOR # (if applicable)	Description of Coverage and/or Intended Use of the Form – Indicate if the Form is New, a Replacement of a Current Form, or to be Withdrawn.

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ACCIDENT AND SICKNESS PROCEDURAL INFORMATION

The filing should be easy to read and understand; it should be self-explanatory and reasonably well-documented. Therefore, it is essential that the proper filing abstracts be completed accurately and in their entirety. Any additional information which may be pertinent to the proposed requests should be included in the filing.

Section 16-29B-24(c) of the Code of West Virginia of 1931, as amended, requires specific additional information to be "incorporated into each proposed rate application" filed with the Insurance Commissioner. The following questions must be addressed in a written report and attached to the filing itself; without this additional information, the filing may be disapproved without further review and/or consideration:

1. What are the economic and social impacts of the proposed rate increase, or coverage decrease, on health care cost containment and upon health care purchasers, such as the elderly and low and fixed income persons?

2. What state-of-the-art advances in insurance and health care management and rate design as alternatives to, or in mitigation of, the proposed rate increase, or coverage decrease, have been investigated and considered? Describe those state-of-the-art advances considered; include specific findings as to each consideration, including the reasons for adoption or rejection of each.

3. What consideration has been given to implementation of cost control systems, including a combination of education, persuasion, financial incentives and disincentives to control costs?

4. What initiatives to create alternative delivery systems have been investigated and considered?

5. What efforts to encourage health care providers to control costs, including the elimination of unnecessary or duplicative facilities and services, the promotion of alternative forms of care, and other cost control mechanisms, have been investigated and considered?

Also, the following questions must be addressed in the written report which is to be attached to the filing; without this additional information, the filing may be disapproved without further review and/or consideration:

6. If the methods used in this filing differ from those used in previous rate filings for this coverage in West Virginia, or if the West Virginia methods differ from those used countrywide, please explain in detail.

7. Explain any adjustments for large or catastrophic losses, if any, that were made in the statistical information on losses.

8. Why is it necessary to request the proposed premium rate adjustment, or coverage decrease, at this time? Please be specific and complete.

INSURANCE COMMISSIONER
STATE OF WEST VIRGINIA

ACCIDENT AND SICKNESS INSURANCES
RATE FILING ABSTRACT

INSTRUCTIONS: All questions must be answered; if no answer is applicable, enter the reason for such determination. USE A SEPARATE ABSTRACT FOR EACH POLICY FORM AFFECTED, OR FOR EACH PROPOSED PREMIUM RATE ADJUSTMENT. If this filing is a combination rate and form filing, the Form Filing Abstract Form ASA-F-83 must also be completed.

1. Date Filed: _____ Proposed Effective Date: _____

2. Company Name: _____

3. Policy/Contract Type(s) Affected

4. Number of West Virginia policyholders (exposure units) affected by this proposed premium rate adjustment:

Single Insureds: _____ Family Insureds: _____

5. Average Current and Proposed Premium Rate Levels Indicate the mode for each:

CURRENT RATE: Single Insured: \$ _____ Family Insured: \$ _____
PROPOSED RATE: Single Insured: \$ _____ Family Insured: \$ _____

6. List all rate level changes for the last five years for the policy/contract type(s) affected by this proposed premium rate adjustment:

WEST VIRGINIA:	EFFECTIVE DATES	PERCENTAGE ADJUSTMENTS
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COUNTRYWIDE:

7. Underwriting Loss Experience List on a year-by-year basis for the past three years, and aggregately for the lifetime of the policy/contract(s) affected:

WEST VIRGINIA (ONLY)

	Earned Premiums	Incurred Losses	Loss Ratios
3rd Prior Year: 19__:	_____	_____	_____
2nd Prior Year: 19__:	_____	_____	_____
1st Prior Year: 19__:	_____	_____	_____
Lifetime Aggregately	_____	_____	_____

COUNTRYWIDE

	Earned Premiums	Incurred Losses	Loss Ratios
3rd Prior Year: 19__:	_____	_____	_____
2nd Prior Year: 19__:	_____	_____	_____
1st Prior Year: 19__:	_____	_____	_____
Lifetime Aggregately	_____	_____	_____

8. Permissible Loss Ratio of the policy/contract(s) affected: _____

Has the Permissible Loss Ratio been adjusted since the inception of the policy/contract(s) affected by this proposed adjustment? If "yes," give details and dates:

9. Estimated Premium Effect of this proposed premium rate adjustment:

Coverage Form	Annual Written Premium	Proposed Adjustment	Additional Annual Premium
_____	_____	_____%	_____

10. If the proposed premium rate adjustment is approved as submitted, what is the range of percentage changes in current premium rate levels that will be felt by the policyholders?

"If the proposed adjustment is approved, the current premium levels may be changed as little as %, or as great as %, with an overall of _____%."

Form ASA-R-83 (Pg. 2)

11. The amount of Annual Written Premium entered in Question 9 of this Rate Filing Abstract accounts for what proportion of the total annual written premium on a countrywide basis for this particular policy/contract? Please be specific in both total dollars and percentage-proportions in West Virginia:

12. Has this proposed premium rate adjustment filing been submitted to any other state insurance departments? if "yes," give specific information as to which states, when filed, each state's proportionate share of the total annual written premium for this particular policy/contract, the status of said filing in each state, and any other pertinent information which may be helpful in our review. Please attach additional sheets if more space is needed.

13. Section 16-29B-24(b) of the Code of West Virginia of 1931, as amended, requires that a copy of any rate and/or coverage filing must be submitted to the West Virginia Health Care Cost Review Authority, West Virginia Department of Health, on or before such filing is submitted to the Insurance Commissioner. Please enter the date on which a copy of this filing was submitted to said Authority:

CERTIFICATION: I hereby certify that the information contained in this Rate Filing Abstract is true and correct to the best of my knowledge and belief, and that a true and complete copy of this entire filing has been submitted to the West Virginia Health Care Cost Review Authority as stated herein.

(Signed) _____

(Title) _____

